DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 0 — 1 1

2. STATE: MICHIGAN

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2000

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
1905(a)(26) and 1934

7. FEDERAL BUDGET IMPACT:
a. FFY 2001 $ -0-
b. FFY 2002 $ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
preprints: 19c, 20c, Attachment 3.1-A pg. 11, Attachment 3.1-B pg. 10, Supplement 3 to Attachment 3.1-A pgs. 1 thru 9

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
N/A - new pages

10. SUBJECT OF AMENDMENT:
Add PACE services to Michigan Medicaid Program

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: James K. Haveman, Jr.

14. TITLE: Director

15. DATE SUBMITTED: 12-28-2000

16. RETURN TO:
Michigan Department of Community Health
Office of Federal Liaison
Lewis Cass Building, 6th Floor
320 S. Walnut Street
Lansing, MI 48913
ATTENTION: N. Bishop

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 12/29/00

18. DATE APPROVED: 8/31/01

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 10/1/2000

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Cheryl A. Harris

22. TITLE: Associate Regional Administrator
Division of Medicaid and Children's Health

23. REMARKS:

RECEIVED
DEC 29 2000
DMIO - MI/MN/WI

FORM HCFA-179 (07-92)

Instructions on Back

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Citation		
	3.1(a)(1)	Amount, Duration and Scope of Services: Categorically Needy (continued)
1905(a)(26) and 1934	(xi) X	Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 2 to Attachment 3.1-A

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy. (Note: Other programs to be offered to Categorically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Categorically Needy beneficiaries would also list the additional coverage that is in excess of established service limits for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.)

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Citation	3.1(a)(2)	Amount, Duration and Scope of Services: Medically Needy (continued)
1905(a)(26) and 1934	(xii) X	Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 2 to Attachment 3.1-A ATTACHMENT 3.1-B identifies services provided to the medically needy. (Note: Other programs to be offered to Medically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Medically Needy beneficiaries would also list the additional coverage that is in excess of established service limits for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.)

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AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

27. Program Of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 2 to Attachment 3.1-A.

X Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

_ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

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AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE SERVICES PROVIDED TO THE MEDICALLY NEEDY

26. Program Of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 2 to Attachment 3.1-A.

X Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

_ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

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PACE Services:

_ The State of _____ has not entered into any valid program agreements with a PACE provider and the Secretary of the Department of Health and Human Services.

_ The State of Michigan has entered into a valid program agreement(s) with a PACE provider(s) and the Secretary, as follows:

Name and address of State Administering Agency, if different from the State Medicaid Agency:

I. Eligibility
The State determines eligibility for PACE enrollees under rules applying to community groups.

A. _X_ The State determines eligibility for PACE enrollees under rules applying to institutional groups as provided for in section 1902(a)(10)(A)(ii)(VI) of the Act (42 CFR 435.217 in regulations). The State has elected to cover under its State plan the optional categorically needy eligibility groups specified under these provisions in the statute and regulations. The applicable groups are:
Please see page 1a of Supplement 2, ATTACHMENT 3.1-A

B. _____ The State determines eligibility for PACE enrollees under rules applying to institutional groups, but chooses not to apply post-eligibility treatment of income rules to those individuals. (If this option is selected, skip to II – PACE Entity Qualifications.)

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I. Eligibility

B. The applicable institutional eligibility groups the State has elected to cover, identified by statutory and/or regulatory reference.

Eligibility Groups	**Statutory and/or Regulatory Reference**
A special income level equal to 300% of the SSI Federal benefit.	42 CFR 435.236 42 CFR 435.17
Medically needy without spend down in States which also provide Medicaid to recipients of SSI.	42 CFR 435.320 42 CFR 435.322 42 CFR 435.324
Aged and disabled who have income at 100% of the Federal Poverty Level (FPL.)	Social Security Act Section 1902 (m)1902(r)(2.)

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PACE Services (continued):

C. __X__ The State determines eligibility for PACE enrollees under rules applying to institutional groups, and applies post-eligibility treatment of income rules to those individuals as specified below. Note that the post-eligibility treatment of income rules specified below are the same as those that apply to the State's approved HCBS waiver(s).

Regular Post Eligibility

1. __X__ SSI State: The State is using the post-eligibility rules at 42 CFR 435.726. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(a). Sec. 435.726 – States which do not use more restrictive eligibility requirements than SSI.

1. Allowances for the needs of the:
   (A) Individual (check one)
      1. ___ The following standard included under the State plan (check one):
         (a) ____ SSI
         (b) ____ Medically Needy
         (c) ____ The special income level for the institutionalized
         (d) ____ Percent of the federal poverty level: ____%
         (e) ____ Other (specify):_____
      2. __X__ The following dollar amount: $300% of Federal Benefit Rate
         Note: If this amount changes, this item will be revised
      3. ____ The following formula is used to determine the needs allowance:
         _____
         _____

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

   (B) Spouse only (check one):
      1. _____ SSI Standard
      2. _____ Optional State Supplement Standard
      3. _____ Medically Needy Income Standard

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PACE Services (continued):

(B) Spouse only (continued)

4. _____ The following dollar amount $_____
Note: If this amount changes, this item will be revised.

5. _____ The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.

6. _____ The amount is determined using the following formula:
_____
_____

7. _____ Not applicable (N/A)

(B) Family (check one):

1. _____ AFDC need standard
2. _____ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3. _____ The following dollar amount: $ _____
Note: If this amount changes, this item will be revised.

4. _____ The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.

5. _____ The amount is determined using the following formula:
_____
_____

6. _____ Other: _____

7. _____ Not applicable (N/A)

(2). Medical and remedial care expensed in 42 CFR 435.726

Regular Post Eligibility

2. ___ 209 (b) State, a State that is using more restrictive eligibility requirements than SSI. The State is using the post-eligibility rules at 42 CFR 435.735. Payment for PACE services is reduced by the amount remaining after deducting the following amounts for the PACE enrollee income.

(a) 42 CFR 435.735 – States using more restrictive requirements than SSI.

1. Allowances for the needs of the
(A) Individual (check one):

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PACE Services (Allowances for the needs of the individual - continued):

1.___ The following standard included under the State Plan (check one):
(a)____ SSI
(b)____ Medically Needy
(c)____The special income level for the institutionalized
(d)____ Percent of the Federal Poverty Level: _____%
(e)____Other (specify): _____

2. ___ The following dollar amount $_____
Note: If this amount changes, this item will be revised.
3. ___ The following formula is used to determine the needs allowance:
_____
_____

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

(B) Spouse only (check one):
1. ___ The following standard under 42 CFR 435.121:
_____
2. ___ The Medically needy income standard
_____
3. ___ The following dollar amount $_____
Note: If this amount changes, this item will be revised.
4. ___ The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.
5. ___ The amount is determined using the following formula:
_____
_____
6. ___ Not applicable (N/A)

C) Family (check one):
1. ___ AFDC need standard
2. ___ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3. ___ The following dollar amount: $ _____
Note: If this amount changes, this item will be revised.

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PACE Services (Allowances for the needs of the family - continued):

4. ___ The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.
5. ___ The amount is determined using the following formula:
_____
_____
6. ___ Other
7. ___ Not applicable (N/A)

(b) Medical and remedial care expenses specified in 42 CFR 435.735

Spousal Post Eligibility

3. ___ State uses the post-eligibility rules of Section 1924 of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of PACE services if it determines the individual's eligibility under section 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(a) Allowances for the needs of the:

1. Individual (check one):

(A)___ The following standard included under the State plan (check one):
1. ___ SSI
2. ___ Medically Needy
3. ___ The special income level for the institutionalized
4. ___ Percent of the Federal Poverty Level: _____%
5. ___ Other (specify): _____

(B) ___ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

(C) ___ The following formula is used to determine the needs allowance:
_____
_____

If this amount is different than the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community:

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II. Program Agreement: For State Medicaid Agencies also serving as PACE State Administering Agencies, the State assures that it is willing to enter into a program agreement with the applicant entity covering the services listed below.

III. Compliance and State Monitoring of the PACE Program

For State Medicaid Agencies also serving as PACE State Administering Agencies, the State further assures all requirements of section 1934 of the Social Security Act will be met. All relevant provisions are included in the contract with the PACE entities, either as contractor or State responsibility. Both scheduled and unscheduled on-site reviews will be conducted by State staff.

A. Readiness Review: The State will perform a Readiness Review of the applicant entity that assures the entity has fully developed its policies and procedures, obtained commitments from key staff, developed its solvency plan and has a facility that meets State and Federal requirements at the time of the application, in accordance with Section 460.12(b)(1).

B. Monitoring During Trial Period: During the trial period, the State, in cooperation with HCFA, will conduct comprehensive reviews of a PACE organization to ensure compliance with State and federal requirements.

At the conclusion of the trial period, the State, in cooperation with HCFA, will continue to conduct reviews of a PACE organization, as appropriate, taking into account the quality of care furnished and the organization's compliance with State and federal requirements

C. Annual Monitoring: The State assures that at least annually it will reevaluate whether a participant meets the level of care required under the State Medicaid plan for coverage of nursing facility services. The State understands that this determination may be waived if there is no reasonable expectation of improvement or significant change in the participant's conditions because of the severity of a chronic condition or the degree of impairment of functional capacity.

D. Monitoring of Corrective Action Plans: The State assures it will monitor the effectiveness of corrective actions required to be taken by the PACE organization.

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IV. Rates and Payments

A. The State assures HCFA that the capitated rates will be equal to or less than the cost to the agency of providing those same fee-for-service State plan approved services on a fee-for-service basis, to an equivalent non-enrolled population group based upon the following methodology. Please attach a description of the negotiated rate setting methodology and how the State will ensure that rates are less than the cost in fee-for-service. Please refer to the attached rate setting information specific to Michigan.

1. _X_ Rates are set at a percent of fee-for-service costs
2. ___ Experience-based (contractors/State's cost experience or encounter date)(please describe)
3. ___ Adjusted Community Rate (please describe)
4. ___ Other (please describe)

B. _X_ The rates were set in a reasonable and predictable manner. *The name of the actuary that calculated the PACE rates is Milliman and Robertson Inc. Actuaries and Consultants.* The Medicaid portion of the Pace rates are rebased every fourth year by selecting a time period where costs and eligibility data are stable and computing the costs of persons who are dually eligible and who meet the nursing home level of care for the remainder of the year following their having a nursing home stay. Costs are broken down into five provider type categories: nursing facility/inpatient facility, outpatient facility, physician services, ancillary services, and pharmacy. These cost components are computed using Medicaid claims and eligibility data stored on the Michigan data warehouse.

Cost are then aggregated into per member per month costs and updated for inflation and other trends to bring them into the payment period using inflationary adjustors. This analysis is completed by or with the assistance of professional actuaries. Rates are discounted five percent. In the initial analysis and the years subsequent to rebasing computations, base rates are updated using inflationary factors for each provider cost category. Inflation factors are the DRI McGraw Hill Skilled Nursing Home Market Basket for the Institutional component and actuarial trends and explicit budgetary increases for the remaining provider categories.

C. _X_ The State will submit all capitated rates to the HCFA Regional Office for prior approval.

V. Enrollment and Disenrollment: For both State Medicaid Agencies and State Administering Agencies, the State assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the State's management information system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month. In cases where the State Medicaid Agency is separate from the State Administering Agency, the State Medicaid Agency assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the two agencies.

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Enrollment and Disenrollment (cont)

A. **Enrollment Process**: Prior to initiating the enrollment process with MDCH an application for Medicaid eligibility is submitted by the PACE provider to the Family Independence Agency. Medicaid eligibility is determined by the Family Independence Agency and communicated to the PACE provider. The Family Independence Agency adds Medicaid eligibility to the client information system. The PACE provider then initiates the enrollment process with the Michigan Department of Community Health (MDCH). This is done by providing a signed, completed enrollment request form from the beneficiary. MDCH adds to the client information system the provider identification number and level of care to indicate PACE enrollment of that participant. The beneficiary's enrollment in the PACE program is effective the first day of the month following receipt of the signed, completed application. On a monthly basis the PACE provider receives a report from the listing all existing enrollees, new enrollees, and disenrollments. MDCH enrolls and pays only for those enrolled PACE clients whose eligibility file reflects Medicaid program approval by the Family Independence Agency. MDCH provides a monthly capitated payment for clients enrolled as of Medicaid card cut off for the month. On a quarterly basis a financial reconciliation is done linking both the enrollment file and eligibility file information from the client information system. Annual and bi-annual recertification of the need for nursing home level of care (LOC) is done by the PACE provider using MDCH criteria. A recommendation is made to MDCH by the PACE provider as to LOC. The LOC determination is done through medical record review after the results of the six and twelve month reassessment have included in the record. A database program tracks frequency of reassessments to insure timeliness of recertification.

B. **Enrollee Information**: The enrollee will receive at least the following written materials:
   - notification of the participant's effective date of enrollment;
   - information about the conditions of enrollment in the plan and scope, content, duration and limitation of coverage;
   - an explanation of the procedure of obtaining benefits, including the address and telephone number of primary care physicians, and the hours and days the facilities are open and service is available;
   - where and how emergency medical care is available on a twenty-four (24) hour, seven days a week basis, and an explanation of out-of-plan coverage;
   - notification that loss of Medicaid eligibility will likewise result in loss of plan enrollment, unless the beneficiary chooses to continue participation in the program by paying the Medicaid portion of the cost;
   - notification of the participant's responsibility for reporting any third party payment resources;
   - a copy of the PACE program's grievance procedure as approved by MDCH. A copy of the MDCH Fair Hearing process (the form for requesting a hearing is on the back of the hearing process form), and the Notice of Adverse Action (beneficiary letter for

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Enrollee Information (cont.)

denial/reduction of services or payment) plus information regarding reasons and procedures for disenrollment from PACE. The Pace provider will secure translation services for participants whose primary language is not English. Translation will be for the completion of the Fair Hearing form and for the hearing. A reference to assistance with understanding the form and the availability of assistance in understanding the form in English, Spanish, and Arabic is included on the bottom of the MDCH hearing form. The toll free number on the bottom of the MDCH hearing form can be used to obtain translation assistance.

- The Fair Hearing process consists of the following: A participant can request an administrative hearing within 90 days of receipt of a written decision the participant disagrees with. An administrative hearing is an impartial review of a decision made by the Department (or one of its contracted agencies) that the appellant (participant, beneficiary, resident, patient, consumer, or responsible party) believes is inappropriate. The appellant may choose to have another person represent them at the hearing. If the appellant has questions or needs assistance, they may call the toll-free number listed on the Department's hearing form. The hearing instructions and form is provided to the PACE provider by the Department. The beneficiary is not required to use the form to request a hearing. The only requirement is that the request be in **writing**, **signed** by the beneficiary or the beneficiary's authorized representative, and that a telephone number or address **where the participant can be contacted** is clearly stated. After the form or written request is completed and signed it must be mailed to the Administrative Tribunal, Michigan Department of Community Health. An addressed, postage paid envelope is provided with the form. Once the Administrative Tribunal receives the request for hearing the hearing will be scheduled, and a notice mailed to the beneficiary or their representative within 30 days. Changes to the hearing process must be communicated to participants within 30 days of approval by MDCH. All other changes must be communicated within 90 days of MDCH approval.

C. **Disenrollment Process**: A PACE participant may voluntarily disenroll without cause at any time. PACE coverage for that participant continues until the last day of the month during which notification is received by the Department. The participant can notify the PACE provider in writing, through personal contact, or telephone. The PACE provider coordinates disenrollment from Medicaid and Medicare. A disenrollment form for Medicaid is faxed by the PACE provider to the Department. Disenrollement from Medicare is added to the deletions form and faxed to HCFA. The Department will initiate enrollment in an alternate managed care program if the participant remains eligible for Medicaid and qualifies for placement in managed care. If the eligible participant does not qualify for managed care, their Medicaid coverage reverts back to fee for service. Involuntary disenrollment may be for any of the following reasons:

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Disenrollment Process (cont)

- The participant fails to pay, or to make satisfactory arrangements to pay, any premium due the PACE organization after a 30-day grace period.
- The participant engages in disruptive or threatening behavior, as described below.
  - A participant whose behavior jeopardizes his or her safety, or the safety of others; or
  - A participant with decision-making capacity who consistently refuses to comply with his or her individual plan of care or the terms of the PACE enrollment agreement.
- The participant moves out of the PACE program area or is out of the service area for more than 30 consecutive days, unless the PACE organization agrees to a longer absence due to extenuating circumstances.
- The participant is determined to no longer meet the State Medicaid nursing facility level of care requirements and is not deemed eligible.

- The PACE program agreement with HCFA and the State Administering Agency is not renewed or is terminated.

- The PACE organization is unable to offer health care services due to the loss of State licenses or contracts with outside providers.

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Enrolment and Disenrollment (cont.)

D. The State assures that before an involuntary disenrollment is effective, it will review and determine in a timely manner that the PACE organization has adequately documented grounds for disenrollment.

E. In the event a PACE participant disenrolls or is disenrolled form a PACE program, the State will work with the PACE organization to assure the participant has access to care during the transitional period.

F. The State assures it will facilitate reinstatement in other Medicaid/Medicare programs after a participant disenrolls.

G. The State assures that the State PACE requirements and State procedures will specify the process for how the PACE organization must submit participant information to the State.

VI. Marketing: For State Medicaid Agencies also acting as PACE State Administering Agencies, the State assures that a process is in place to review PACE marketing materials in compliance with Section 460.82 (b)(ii).

VII. The State assures that the state agency that administers the PACE program will regularly consult the State Agency on Aging in overseeing the operation of the PACE program in order to avoid services duplication in the PACE service area and to assure the delivery and quality of services to the PACE participants.

VIII. Decisions that require joint HCFA/State Authority

A. For State Medicaid Agencies also acting as PACE State Administering Agencies, waivers will not be granted without joint HCFA/State agreement.

1. The State will consult with HCFA to determine the feasibility of granting any waivers related to the conflicts of interest of PACE organization governing board members.

2. The State will consult with HCFA to determine the feasibility of granting any waivers related to the requirements that: members of the multidisciplinary team are employees of the PACE organization; and that members of the multi-disciplinary team must serve primarily PACE participants.

B. Service Area Designations: The State will consult with HCFA on changes proposed by the PACE organization related to service area designation.

C. Organizational Structure: The State will consult with HCFA on changes proposed by the PACE organization related to organizational structure.

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D. Sanctions and Terminations: The State will consult with HCFA on termination and sanctions of the PACE organization.

IX. State Licensure Requirements: For State Medicaid Agencies also acting as PACE State Administering Agencies, the State assures that Life Safety Code requirements are met for facilities in which the PACE organization furnishes services to PACE participants in accordance with Section 460.72(b), unless HCFA determines that a fire and safety code imposed by State law adequately protects participants and staff.